Employee Application

Return completed form to your group's Benefits Department

City of St Peter

Long Term Disability

Employee Information

EMPLOYER				POLICY NUMBER	UNIT
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)			DATE OF EMPLOYMENT	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
DATE OF BIRTH (Mo, Day, Yr)	ANNUAL SALARY	☐ MALE ☐ FEMALE	MARRIAGE DATE	EMAIL ADDRESS	
BUSINESS PHONE	HOME PHONE		# OF HOURS WORKED PER WEEK	JOB TITLE	

Long Term Disability Benefits

☐ Newly Elected
☐ Change

You may select the Long Term Disability monthly benefit below.
Regardless of election, the benefit may not exceed 60% of your monthly earnings.

Present Amount	(+,-) Increase/Decrease	Grand Total	Effective Date of Change
$_____	$_____	$_____	_____

☐ I waive or cancel Long Term Disability

I have been given the opportunity to enroll in my employer's Long Term Disability plan. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurance carrier and understand my request for coverage may be denied.

In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual.

I hereby apply for (or request change in) coverages as indicated above for which I am eligible under contracts of group insurance issued to my employer. I understand that some coverages require approval of my insurability before they become effective, I authorize payroll deductions for my share of the premiums.

DATE OF APPLICATION	SIGNATURE OF EMPLOYEE